

SB237_L.001

SENATE COMMITTEE OF REFERENCE AMENDMENT

Committee on Health & Human Services.

SB18-237 be amended as follows:

- 1 Amend printed bill, page 2, strike line 3 and substitute "(3)(a)(III) and
2 (5.5)(a) introductory portion; and add (12)".
- 3 Page 2, line 4, strike "and (13)".
- 4 Page 2, line 6, strike "- limitations on balance billing -".
- 5 Page 3, line 1, strike "independent dispute resolution process".
- 6 Page 3, lines 17 and 18, strike "that provides any benefits with respect to
7 services" and substitute "that provides any benefits with respect to
8 EMERGENCY services".
- 9 Page 3, line 19, after "cover" insert "THE".
- 10 Page 3, strike lines 20 through 24.
- 11 Page 3, lines 25 and 26, strike "JANUARY 1, 2019, HEALTH CARE
12 FACILITIES, CARRIERS, AND PROVIDERS" and substitute "JULY 1, 2019,
13 CARRIERS".
- 14 Page 4, line 1, after "NONEMERGENCY" insert "OR EMERGENCY".
- 15 Page 4, line 2, strike "EMERGENCY SERVICES".
- 16 Page 4, strike lines 4 and 5 and substitute "SUBSECTION (12)(b) OF THIS
17 SECTION."
- 18 Page 4, lines 12 and 13, strike "BOTH EMERGENCY AND NONEMERGENCY
19 SERVICES;" and substitute "NONEMERGENCY SERVICES AND THE TIMING
20 FOR PROVIDING THE DISCLOSURES FOR EMERGENCY SERVICES AFTER
21 PERFORMING AN APPROPRIATE MEDICAL SCREENING EXAMINATION AND
22 DETERMINING THAT A PATIENT DOES NOT HAVE AN EMERGENCY MEDICAL
23 CONDITION OR AFTER TREATMENT HAS BEEN PROVIDED TO STABILIZE AN
24 EMERGENCY MEDICAL CONDITION;"
- 25 Page 4, line 16, strike "AND" and substitute "OR".
- 26 Page 4, lines 22 and 23, strike "FACILITIES, OUT-OF-NETWORK PROVIDERS,
27 AND".

- 1 Page 4, line 27, strike "AND".
- 2 Page 5, line 4, after "(12)" insert "AND SECTIONS 24-34-113 AND
3 25-3-118".
- 4 Page 5, line 5, after "24-34-113" insert "(1)(b)".
- 5 Page 5, strike lines 6 through 26 and substitute "AND 25-3-118 (1)(b); AND
6 (VI) REQUIREMENTS ABOUT THE TIMELY SHARING OF
7 INFORMATION REGARDING COST-SHARING OBLIGATIONS AND IN-NETWORK
8 BENEFITS AMONG CARRIERS, PROVIDERS, AND HEALTH CARE FACILITIES.
9 (c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION
10 (12) DOES NOT WAIVE A COVERED PERSON'S PROTECTIONS UNDER
11 SUBSECTIONS (3)(b) AND (5.5) OF THIS SECTION."
- 12 Page 6, line 2, strike "rules." and substitute "rules - required
13 repayments. (1) (a) ON AND AFTER JULY 1, 2019, HEALTH CARE
14 PROVIDERS SHALL DEVELOP AND PROVIDE CONSUMERS DISCLOSURES
15 ABOUT THE POTENTIAL EFFECTS OF RECEIVING NONEMERGENCY OR
16 EMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE
17 DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED UNDER
18 SUBSECTION (1)(b) OF THIS SECTION."
- 19 Page 6, line 3, strike "THE" and substitute:
20 "(b) THE".
- 21 Page 6, line 7, strike "SECTION 10-16-704 (12)." and substitute "THIS
22 SECTION."
- 23 Page 6, line 8, strike "SECTION 10-16-704 (12)" and substitute "SECTIONS
24 10-16-704 (12) AND 25-3-118 (1)".
- 25 Page 6, line 9, strike "THAT SECTION" and substitute "SECTION 10-16-704
26 (12)(b)".
- 27 Page 6, line 10, strike "25-1-108 (1)(i)." and substitute "25-3-118 (1)(b).
28 THE RULES MUST INCLUDE, AT A MINIMUM, THE FOLLOWING:
29 (I) THE TIMING FOR PROVIDING THE DISCLOSURES FOR
30 NONEMERGENCY SERVICES AND THE TIMING FOR PROVIDING THE
31 DISCLOSURES FOR EMERGENCY SERVICES AFTER PERFORMING AN
32 APPROPRIATE MEDICAL SCREENING EXAMINATION AND DETERMINING THAT
33 A PATIENT DOES NOT HAVE AN EMERGENCY MEDICAL CONDITION OR AFTER

1 TREATMENT HAS BEEN PROVIDED TO STABILIZE AN EMERGENCY MEDICAL
2 CONDITION;

3 (II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
4 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
5 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
6 COMMUNICATIONS WITH CONSUMERS;

7 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
8 CONSUMER'S RIGHT TO CONTACT THE DIVISION OF INSURANCE REGARDING
9 THE BILL THE CONSUMER RECEIVES FOR HEALTH CARE SERVICES PROVIDED
10 BY THE HEALTH CARE PROVIDER;

11 (IV) DISCLOSURE REQUIREMENTS SPECIFIC TO PROVIDERS,
12 INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK
13 PROVIDER, WHETHER A PROVIDER IS OUT OF NETWORK, THE TYPES OF
14 SERVICES AN OUT-OF-NETWORK PROVIDER MAY RENDER, AND THE RIGHT
15 TO REQUEST AN IN-NETWORK PROVIDER TO RENDER SERVICES;

16 (V) REQUIREMENTS ABOUT THE WORDING TO BE USED IN THE
17 DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
18 INSURERS, HEALTH CARE FACILITIES, AND PROVIDERS USE CONSISTENT
19 WORDING IN THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS
20 10-16-704 (12) AND 25-3-118 AND THE RULES ADOPTED PURSUANT TO
21 THIS SECTION AND SECTIONS 10-16-704 (12)(b) AND 25-3-118 (1)(b); AND

22 (VI) REQUIREMENTS ABOUT THE TIMELY SHARING OF
23 INFORMATION REGARDING COST-SHARING OBLIGATIONS AND IN-NETWORK
24 BENEFITS AMONG CARRIERS, PROVIDERS, AND HEALTH CARE FACILITIES.

25 (c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION
26 (1) DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTIONS
27 10-16-704 (3)(b) AND (5.5).

28 (2) (a) WITH REGARD TO EMERGENCY OR NONEMERGENCY
29 SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER AT AN
30 IN-NETWORK FACILITY OR SERVICES PROVIDED BY AN OUT-OF-NETWORK
31 PROVIDER AT AN OUT-OF-NETWORK FACILITY, IF THE OUT-OF-NETWORK
32 PROVIDER IS PROVIDED WITH INFORMATION ON THE IN-NETWORK BENEFIT
33 FROM THE CONSUMER'S HEALTH PLAN AND COLLECTS PAYMENTS FROM THE
34 CONSUMER FOR A BALANCE BILL, AS DEFINED IN SECTION 10-16-704
35 (2)(f)(I), THAT IS SUBSEQUENTLY DETERMINED NOT TO BE THE FINANCIAL
36 RESPONSIBILITY OF THE CONSUMER, THE OUT-OF-NETWORK PROVIDER
37 SHALL REIMBURSE THE CONSUMER FOR THOSE PAYMENTS, LESS ANY
38 APPLICABLE COPAYMENTS, DEDUCTIBLES, OR COINSURANCE AMOUNTS,
39 WITHIN FORTY-FIVE CALENDAR DAYS AFTER RECEIVING A COPY OF THE
40 CONSUMER'S EXPLANATION OF BENEFITS THAT SHOWS THE COST-SHARING
41 AMOUNTS FOR WHICH THE CONSUMER IS RESPONSIBLE.

42 (b) IF THE OUT-OF-NETWORK PROVIDER DOES NOT REFUND THE
43 OVERPAYMENT AMOUNT TO THE CONSUMER WITHIN FORTY-FIVE

1 CALENDAR DAYS AFTER RECEIVING THE EXPLANATION OF BENEFITS,
2 INTEREST ACCRUES ON THE OVERPAYMENT AMOUNT AT THE RATE OF TEN
3 PERCENT PER ANNUM, STARTING ON THE DATE THE EXPLANATION OF
4 BENEFITS WAS RECEIVED.

5 (c) AN OUT-OF-NETWORK PROVIDER SHALL AUTOMATICALLY
6 INCLUDE IN THE REFUND TO THE CONSUMER ALL ACCRUED INTEREST
7 PURSUANT TO THIS SUBSECTION (2) WITHOUT REQUIRING THE CONSUMER
8 TO SUBMIT A REQUEST FOR THE INTEREST AMOUNT."

9 Page 6, strike lines 11 through 17 and substitute:

10 "SECTION 3. In Colorado Revised Statutes, add 25-3-118 as
11 follows:

12 **25-3-118. Health care facilities - required disclosures - rules**
13 **- required repayments.** (1) (a) ON AND AFTER JULY 1, 2019, HEALTH
14 CARE FACILITIES SHALL DEVELOP AND PROVIDE CONSUMERS DISCLOSURES
15 ABOUT THE POTENTIAL EFFECTS OF RECEIVING NONEMERGENCY SERVICES
16 FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT AN
17 IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK
18 FACILITY. THE DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED
19 UNDER SUBSECTION (1)(b) OF THIS SECTION.

20 (b) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE
21 COMMISSIONER".

22 Page 6, line 19, after "AGENCIES," insert "SHALL ADOPT RULES".

23 Page 6, lines 21 and 22, strike "SECTION 10-16-704.(12)." and substitute
24 "THIS SECTION."

25 Page 6, line 23, strike "SECTION 10-16-704 (12)" and substitute "SECTIONS
26 10-16-704 (12) AND 24-34-113 (1)".

27 Page 6, line 24, strike "THAT SECTION" and substitute "SECTION 10-16-704
28 (12)(b)".

29 Page 6, line 25, strike "24-34-113." and substitute "24-34-113 (1)(b). THE
30 RULES MUST INCLUDE, AT A MINIMUM, THE FOLLOWING:

31 (I) THE TIMING FOR PROVIDING THE DISCLOSURES FOR
32 NONEMERGENCY SERVICES AND THE TIMING FOR PROVIDING THE
33 DISCLOSURES FOR EMERGENCY SERVICES AFTER PERFORMING AN
34 APPROPRIATE MEDICAL SCREENING EXAMINATION AND DETERMINING THAT
35 A PATIENT DOES NOT HAVE AN EMERGENCY MEDICAL CONDITION OR AFTER
36 TREATMENT HAS BEEN PROVIDED TO STABILIZE AN EMERGENCY MEDICAL

1 CONDITION;

2 (II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
3 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
4 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
5 COMMUNICATIONS WITH CONSUMERS;

6 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
7 CONSUMER'S RIGHT TO CONTACT THE DIVISION OF INSURANCE REGARDING
8 THE BILL THE CONSUMER RECEIVES FOR HEALTH CARE SERVICES PROVIDED
9 BY THE HEALTH CARE FACILITY;

10 (IV) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH FACILITIES,
11 INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK
12 PROVIDER AT AN IN-NETWORK FACILITY, WHETHER THE FACILITY IS OUT OF
13 NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK PROVIDER MAY
14 RENDER AT AN IN-NETWORK FACILITY, AND THE RIGHT TO REQUEST AN
15 IN-NETWORK PROVIDER TO RENDER SERVICES AT THE FACILITY;

16 (V) REQUIREMENTS ABOUT THE WORDING TO BE USED IN THE
17 DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
18 INSURERS, HEALTH CARE FACILITIES, AND PROVIDERS USE CONSISTENT
19 WORDING IN THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS
20 10-16-704 (12) AND 24-34-113(1) AND THE RULES ADOPTED PURSUANT TO
21 THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 (1)(b); AND

22 (VI) REQUIREMENTS ABOUT THE TIMELY SHARING OF
23 INFORMATION REGARDING COST-SHARING OBLIGATIONS AND IN-NETWORK
24 BENEFITS AMONG CARRIERS, PROVIDERS, AND HEALTH CARE FACILITIES.

25 (c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION
26 (1) DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTIONS
27 10-16-704 (3)(b) AND (5.5).

28 (2) (a) WITH REGARD TO NONEMERGENCY OR EMERGENCY
29 SERVICES PROVIDED AT AN OUT-OF-NETWORK FACILITY, IF THE
30 OUT-OF-NETWORK FACILITY IS PROVIDED WITH INFORMATION ON THE
31 IN-NETWORK BENEFIT FROM THE CONSUMER'S HEALTH PLAN AND
32 COLLECTS PAYMENTS FROM THE CONSUMER FOR A BALANCE BILL, AS
33 DEFINED IN SECTION 10-16-704 (2)(f)(I), THAT IS SUBSEQUENTLY
34 DETERMINED NOT TO BE THE FINANCIAL RESPONSIBILITY OF THE
35 CONSUMER, THE FACILITY SHALL REIMBURSE THE CONSUMER FOR THOSE
36 PAYMENTS, LESS ANY APPLICABLE COPAYMENTS, DEDUCTIBLES, OR
37 COINSURANCE AMOUNTS, WITHIN FORTY-FIVE CALENDAR DAYS AFTER
38 RECEIVING A COPY OF THE CONSUMER'S EXPLANATION OF BENEFITS THAT
39 SHOWS THE COST-SHARING AMOUNTS FOR WHICH THE CONSUMER IS
40 RESPONSIBLE.

41 (b) IF THE OUT-OF-NETWORK FACILITY DOES NOT REFUND THE
42 OVERPAYMENT AMOUNT TO THE CONSUMER WITHIN FORTY-FIVE
43 CALENDAR DAYS AFTER RECEIVING THE EXPLANATION OF BENEFITS,

1 INTEREST ACCRUES ON THE OVERPAYMENT AMOUNT AT THE RATE OF TEN
2 PERCENT PER ANNUM, STARTING ON THE DATE THE EXPLANATION OF
3 BENEFITS WAS RECEIVED.

4 (c) AN OUT-OF-NETWORK FACILITY SHALL AUTOMATICALLY
5 INCLUDE IN THE REFUND TO THE CONSUMER ALL ACCRUED INTEREST
6 PURSUANT TO THIS SUBSECTION (2) WITHOUT REQUIRING THE CONSUMER
7 TO SUBMIT A REQUEST FOR THE INTEREST AMOUNT."

8 Page 1, line 104, strike "REQUIRING CARRIERS TO COVER".

9 Page 1, strike lines 105 and 106 and substitute "REQUIRING".

10 Page 1, lines 110 and 111, strike "BILLING PROCEDURES" and substitute
11 "REPAYMENT REQUIREMENTS".

12 Page 1, line 111, strike "PROVIDERS." and substitute "PROVIDERS AND
13 FACILITIES".

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